STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155654	A. BUILDING 00 B. WING	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENGLEWOOD HEALTH & REHABILITATION CENTER	2237 ENGLE RD FORT WAYNE, IN46809

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F0000	This visit was for a Recertification and State Licensure survey. Survey dates: November 14, 15, 16, and 17, 2011 Facility number: 000498 Provider number: 155654 AIM number: 100266110 Survey Team: Julie Wagoner, RN, TC Tim Long, RN Christine Fodrea, RN Shelley Reed, RN Census bed type: SNF/NF: 61 Total: 61 Census payor type: Medicare: 04 Medicaid: 48 Other: 09 Total: 61 Sample: 16 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed on November	F0000	This Plan of Correction is prepared and executed because the provision of State and Federal law require it and not because Englewood Health and Rehabilitation Center agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor are they of such character so as to limit our capability to render adequate care.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	22, 2011 by Bev Faulkner, RN			
F0279 SS=E	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interview and record review, the facility failed to initiate care plans for 5 of 10 residents reviewed for care plan development. Behavioral care plans were not initiated for 4 of 6 residents reviewed for behavioral care plans (Resident #2, Resident #10, Resident #71 and Resident #57) and 1 of 4 residents reviewed for pressure ulcer prevention care plans (Resident #67) in a sample of 16. Findings include:	F0279	This Plan of Correction is prepared and executed because the provision of State and Federal law require it and not because Englewood Health and Rehabilitation Center agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor are they of such character so as to limit our capability to render adequate care. 1. Resident's # 2, 10, 57 and 67 care plans have been updated to reflect the	12/16/2011

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	1. Resident #2's record was reviewed 11-15-11 at 2:25 p.m. Resident #2's diagnoses included but were not limited to dementia with behavioral disturbances, depression and anemia. Behavior notes, dated 11-8-11 at 9:29 p.m., indicated Resident #2 had been banging on the facility door attempting to catch the bus. When staff attempted to intervene, Resident #2 hit and pushed staff. Behavior notes, dated 11-11-11 at 9:55 p.m., indicated Resident #2 had been yelling at staff to assist her from the dining area. A review of current care plans did not include a care plan to address Resident #2's agitation. In an interview 11-17-11 at 11:25 a.m., the Nurse Consultant indicated a care plan should have been initiated for Resident #2's agitation. 2. Resident #10's record was reviewed 11-16-11 at 2:59 p.m. Resident #10's diagnoses included but were not limited to spine and lung cancer, anxiety and depression.		identified areas. Resident # 71 has been discharged and therefore the facility is unable to correct the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. Care plans for all residents have been reviewed to ensure any behavioral issues and/or medication use have been identified and addressed. 3. Nursing staff to be inserviced on the initiation of behavior care plans and or new medications. An audit of all resident care plans that identify behavioral care plan and prevention of pressure ulcer will be completed by the interdisciplinary care plan team. Admissions/readmissions/behavioral and/or initiation of medication changes to be reviewed each day during the Departmental Morning Meetings. 4. DON or designee will monitor scheduled care plan updates and acknowledge for completion/accuracy for 3 months and report results to QA Committee. Reviews by Social Services to be discussed quarterly during the QA Committee Meetings ongoing. 5. To be completed by 12/16/11.	

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	A Social Service progress note, dated 10-24-11 at 2:51 p.m., indicated Resident #10 had been calling names at others. The note further indicated a behavior plan had been created for verbal abuse. A review of current care plans indicated the plans did not include a care plan to address Resident #10's name calling or verbal abuse. In an interview on 11-17-11 at 11:35 a.m., the Social Services Director indicated a care plan to address Resident #10's name calling should have been completed. 3. Resident #71's closed record was reviewed 11-17-11 at 1:27 p.m. Resident #71's diagnoses included but were not limited to depression, anxiety, and anemia. Resident #71 had been seen by the psychiatric Nurse Practitioner on 8-9-11. Her notes indicated Resident #71 was depressed and could not sleep. There were no nursing progress notes indicating the resident's inability to sleep or signs and/or symptoms of depression. A review of Resident #71's care plans during his stay did not include a care plan to address his depression or inability to sleep.			

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In an interview on 11-17-11 at 2:45 p.m., the Social Services Director indicated a care plan should have been initiated to address Resident #71's depression and inability to sleep.

4. Resident #57's clinical record was reviewed on 11/15/11 at 2:45 P.M. The record indicated the resident was admitted to the facility with diagnoses including, but not limited to, dementia.

On 6/3/11, a physician's order was received to start the resident on Zyprexa (an antipsychotic medication) 5 milligrams (mg) once daily at bedtime for delusional behavior.

A review of the resident's most recent health care plans indicated he did not have a health care plan to address delusional behavior.

A Behavioral Assessment/Incident was documented on 5/17/11, where the resident had verbal aggression, increased confusion, was making false accusations and hearing voices.

A Behavioral Assessment/Incident was documented on 6/5/11, where the resident refused to return to his home unit in the facility and stated someone was trying to

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	kill him. An interview with the Social Service Director (SSD) on 11/16/11 at 10:35 A.M., indicated she believed the medical symptoms for the use of Zyprexa were anxiety, dementia and depression. The SSD indicated the resident should have had a health care plan to address Zyprexa use. An interview with the Director of Nursing (DN) on 11/16/11 at 11:00 A.M., indicated the resident had been put on Zyprexa for delusional behavior. An interview with the DN on 11/17/11 at 9:55 A.M. indicated she located no information about a health care plan for delusional behavior. 5. Resident #67's clinical record was reviewed on 11/15/11 at 10:23 A.M. The record indicated the resident was admitted to the facility on 9/30/11. On 10/16/11, the resident fell and was sent to an acute care facility with a fracture of her left hip. The resident returned to the facility on 10/20/11. On 10/28/11, the resident was found to have Stage I pressure ulcers to bilateral heels. An observation of a dressing change on			

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	11/15/11 at 10:45 A.M., indicated bilateral heels with Stage II pressure ulcers. On 10/14/11, before the resident suffered a hip fracture, the facility conducted a Braden Scale, skin risk assessment indicating the resident had a score of 20, which does not indicate risk for pressure ulcers. On 10/23/11, after the resident suffered a hip fracture, the facility conducted a Braden Scale, skin risk assessment, which indicated the resident had a score of 12, which indicated the resident was high risk for developing pressure ulcers. Review of the resident's health care plan initiated on 10/13/11 for potential for pressure ulcer related to impaired bed mobility and urinary incontinence indicated interventions of: Apply barrier cream as needed; cleanse after incontinence; cushion in wheelchair; encourage resident to change position frequently; notify MD of any red or open areas; pressure reducing mattress; weekly skin assessments. On 10/28/11, after the development of the bilateral heel pressure ulcers the health care plan was updated to include float heels in bed and heel protectors (float boots).			

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	An interview with the Director of Nursing (DN) and Nurse Consultant on 11/17/11 at 10:10 A.M., indicated the facility did not update the health care plan for risk for pressure ulcers after the resident returned to the facility with a hip fracture on 10/20/11. The DN indicated they had a "soft chart" of documentation not on the resident's clinical record which indicated the facility attempted to initiate pressure ulcer prevention interventions for the resident after her return from the hospital on 10/20/11. The DN indicated the Assistant Director of Nursing (ADN) tried to initiate floating of the heels, turning and repositioning but the resident's family refused to allow those interventions to be done. The ADN indicated the family was informed of the risks of the resident not elevating her heels and not turning and repositioning. The DN indicated LPN #7 discussed the same risks of not allowing the interventions of floating the resident's heels and turning and repositioning and the family again stated they did not want those interventions. The DN and the Nurse Consultant indicated a health care plan should have been started to address the family's refusal to allow interventions to prevent the development of pressure ulcers following the fractured hip on 10/20/11. 3.1-35(a)			

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F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on interview and record review, the facility failed to ensure care plans were updated with fall interventions for 1 of 6 residents reviewed for care plan updates in a sample of 16. (Resident #2) Findings include: Resident #2 's record was reviewed 11-15-11 at 2:25 p.m. Resident #2's diagnoses included but were not limited to dementia with behavior, depression, and anemia. Nurse's progress note, dated 11-9-11 at	F0280	This Plan of Correction is prepared and executed because the provision of State and Federal law require it and not because Englewood Health and Rehabilitation Center agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor are they of such character so as to limit our capability to render adequate care. 1. It is the practice of this facility to develop and maintain comprehensive care plans for each resident. The care plan for resident # 2 was updated to reflect encouraging the	12/16/2011

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	8:35 p.m., indicated Resident #2 had fallen in her room. Resident #2's fall investigation worksheet, dated 11-9-11, indicated no new interventions were attempted to prevent falls and to continue with the current care plan. A review of Resident #2's current care plans indicated there was no new updates to the care plan. In an interview on 11-15-11 at 3:10 p.m., the Nurse Consultant indicated the care plan should have been updated. A current policy, dated 6/2005, and titled Care Plans indicated persons on all shifts were responsible to update the care plans to keep the care plan current. 3.1-35(d)(2)(B)		resident to allow staff to assist to bed by 8pm. 2. All other residents have the potential to be affected by the alleged deficient practice. Care plans were reviewed to ensure all were updated according to the residents needs. 3. Nursing staff to be in-serviced regarding the necessity of updating a resident's care plan to reflect an intervention for each shift when applicable by the DON. 4. DON/ADON/Designee to review any occurrences each business day to ensure a care plan review was completed. All occurrences to be reviewed each day during Departmental Morning Meetings discussing care plan changes ongoing. All occurrences will be reviewed quarterly during QA committee meetings ongoing. 5. To be completed by 12/16/11.	
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to follow the health care plan for pressure ulcer prevention for 1 resident reviewed for care plans in a sample of 16. (Resident	F0282	This Plan of Correction is prepared and executed because the provision of State and Federal law require it and not because Englewood Health and Rehabilitation Center agrees with	12/16/2011

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	#24) Findings include: 1. During the initial tour of the facility, conducted on 11/14/11 between 10:30 A.M. - 11:45 A.M., LPN # 2 indicated Resident #24 was confused, required total staff assistance for activities of daily living, was incontinent, and had recent weight loss. The resident was noted to be in bed asleep during the tour. Resident #24 was observed on 11/15/11 at 10:15 A.M., lying in her bed. The resident's feet were noted to be lying directly against her mattress. Resident #24 was observed, on 11/16/11 at 1:30 P.M., lying in her bed. Her feet were noted to be lying directly on her mattress and were covered with a blanket. The clinical record for Resident #24 was reviewed on 11/15/11 at 9:00 A.M. The most recent Minimum Data Set (MDS) assessment, completed on 09/21/11, indicated the resident required extensive staff assistance for bed mobility, and wheelchair locomotion. A health care plan, current through 12/14/11, for pressure ulcer prevention included the following intervention: "...float heels on pillows when in bed..."		the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor are they of such character so as to limit our capability to render adequate care. 1. The facility is unable to correct the alleged previous deficient practice for resident # 24. 2. All other residents have the potential to be affected by the alleged deficient practice. Care plans for all residents have been reviewed to identify others requiring heels needing to be floated. 3. Nursing staff to be in-serviced regarding the necessity of following skin breakdown interventions listed. 4. DON/Designee to conduct rounds twice daily to ensure that heels are being floated according to the care plan. Results of rounds to be reviewed quarterly during QA Committee meetings ongoing. 5. To be completed by 12/16/11.	

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F0309 SS=D	3.1-35(g)(2) Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review, and interviews, the facility failed to ensure 1 of 9 residents reviewed for incontinence was reassessed for bowel incontinence after a decline. (Resident #26) Findings include: 1. During the initial tour of the facility, conducted on 11/14/11 between 10:30 A.M. - 11:45 A.M., LPN #2, indicated Resident #26 usually required minimal assistance with activities of daily living but had been experiencing some recent increase in incontinence, had fallen, and was more confused. Resident #26 was observed on 11/17/11 at 2:00 P.M., lying in her bed. The resident had no clothing on her lower half of her body, was partially uncovered and exposed, with a soiled incontinence pad lying beside her pillow and another incontinence pad lying on the floor by her bed. The resident was noted to be lying	F0309	This Plan of Correction is prepared and executed because the provision of State and Federal law require it and not because Englewood Health and Rehabilitation Center agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor are they of such character so as to limit our capability to render adequate care. 1. The facility initiated a 3 day voiding pattern for resident # 26 on 12-1-11 and a bowel and bladder assessment to be completed 12-5-11. 2. All other residents have the potential to be affected by the alleged deficient practice. Bowel and bladder assessments have been audited to ensure no other resident requires an updated bowel and bladder assessment of their status. 3. Nursing staff to be in-serviced regarding notification to the DON or designeee regarding any changes in bowel or bladder status for follow up of changes by the DON. 4.	12/16/2011

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	close to the outside edge of her bed. Interview with Resident #26's roommate, during the investigation, indicated the resident had "made a mess in the bathroom with both urine and bm (bowel movement)" The roommate indicated she had cleaned up the bathroom. The clinical record for Resident #26 was reviewed on 11/16/11 at 9:20 A.M. Resident #26 was admitted to the facility on 01/28/11. A quarterly Minimum Data Set (MDS) assessment, completed on 07/27/11, indicated the resident was totally alert and oriented and continent of her bowels. An assessment, completed on 10/11/11, due to a significant change indicated the resident was usually alert and oriented but had declined and frequently incontinent of her bowels. Review of the most recent bowel and bladder assessment for Resident #26, completed on 01/28/11, indicated the resident was continent of her bowels and independent with toileting. A quarterly review of the assessment, completed on 08/22/11, indicated the bowel and bladder assessment had been reviewed and "no changes at this time." was written on the form. A bladder and bowel voiding patterning diary was		DON/ADON to review 24 hour report form and daily progress notes in Point of Care computer system to identify any additional concerns regarding bowel and/or bladder status. Reviews of 24 hour report form and daily progress notes to be discussed daily during Departmental Morning Meetings ongoing. QA Committee to review any assessment concerns quarterly when discussing MDS assessments ongoing. 5. To be completed by 12/16/11.	

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	completed, but there was no reassessment of the resident's bowel and bladder when the resident's bowel continency declined. Interview with the Director of Nursing, on 11/17/11 at 12:00 P.M., indicated there should have been a new assessment completed for bowel incontinency, but it had not been done. 3.1-37(a)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure safe storage of chemicals in the therapy department. This had the potential to affect five unidentified residents who walked or wheeled by the therapy room independently. Findings include:	F0323	This Plan of Correction is prepared and executed because the provision of State and Federal law require it and not because Englewood Health and Rehabilitation Center agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor are they of such character so as to limit our capability to render	12/16/2011

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	On 11-14-11 at 12:05 p.m.,the therapy room door was open and the lock on the cabinet was noted to be unlocked. The cabinet contained "Biofreeze" gel and an aerosol canister which read "Surface Disinfectant." Between 12:05 p.m. and 12:07 p.m., five unidentified residents independently walked or wheeled by the open therapy room. On 11-14-11 at 12:07 p.m., Speech Therapist #2 returned to the therapy room and in an interview indicated she had returned from lunch. She further indicated the cabinet should not have been left unlocked and unattended. A Material Safety Data Sheet (MSDS), dated October 2003 and titled Biofreeze, provided by the Administrator on 11-16-11 at 10:15 a.m., indicated to handle the gel with care and have adequate ventilation during handling and not to ingest the product. A Material Safety Data Sheet (MSDS), dated June 13, 2005 and titled Surface Disinfectant and Air Deodorizer, provided by the Administrator on 11-16-11 at 10:15 a.m., indicated the product was flammable and respiratory and eye irritation could occur. The sheet further indicated to flush		adequate care. 1. The cabinet in the therapy department is locked and secure. 2. The Maintenance Supervisor has conducted a QA walkthrough of the building to ensure resident environment remains free of accident hazards. 3. Therapy staff to be in-serviced on the safe storage of chemicals in the therapy room. 4. The Maintenance Supervisor will complete a safety QA tool weekly for the next 6 weeks and quarterly thereafter for monitor for compliance. Results will be forwarded to the QA committee. 5. To be completed by 12/16/11.	

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	eyes with water should exposure occur and to remove the person to fresh air, use oxygen, and seek medical attention should the product be inhaled. In an interview on 11-16-2011 at 10:15 a.m., the Administrator indicated although there was no specific policy regarding chemical storage, chemicals were to be stored in a secure area. 3.1-45(a)(1)			
F0329 SS=E	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, record review, and	F0329	This Plan of Correction is prepared and executed because	12/16/2011

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	interviews, the facility failed to ensure there were adequate indications for the use of psychotropic medications for 2 of 8 residents reviewed for psychotropic medications in a sample of 16. (Residents #2 and 71) In addition, the facility failed to ensure there were adequate indications to support an increase in a psychotropic medication for 1 of 8 residents reviewed for psychotropic medications in a sample of 16. (Resident 26) Finally, the facility failed to ensure there was adequate monitoring of the medical symptoms for which an antipsychotic medication was given for 2 of 8 residents receiving antipsychotic medications in a sample of 16. (Resident #57 and 28) Findings include: 1. Resident #28 was heard screaming out repeatedly on 11/15/11 from 8:30 A.M. - 9:00 A.M. When LPN #5, who was administering medication entered the room, Resident #28 was noted to be screaming in pain, visibly shaking all extremities, and sweaty. The resident received two pain medications and around 10:00 A.M. was noted to be sleeping. On 11/16/11 from 8:40 A.M. :9:00 A.M., Resident #28 was again heard screaming out and was noted to be very anxious and		the provision of State and Federal law require it and not because Englewood Health and Rehabilitation Center agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor are they of such character so as to limit our capability to render adequate care. 1. Clarifications obtained as to what diagnosis was appropriate for the use of Seroquel and whether psychotic features included delusional behavior for resident # 28. The facility is unable to correct the alleged deficient practice of not documenting the resident's delusional behavior. The facility is unable to correct the alleged deficient practice for resident # 26. Risperdal has been decreased to the original order of 0.25 mg and resident # 2 is being observed for any increase in behavioral issues. The facility is unable to correct the alleged deficient practice for resident # 71 as they no longer reside in the facility. Care plan has been updated for resident # 57 to include delusional behavior and the use of Zyprexa. 2. All other residents have the potential to be affected by the alleged deficient practices. All residents receiving psychoactive medications have been reviewed to ensure the diagnosis is appropriate for use of the medications, as well as a care	

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	upset. At 9:00 A.M., LPN #3 was noted to speak quietly with Resident #28, wiped her face with a towel, and tried to reassure the resident that the only people in the room were herself, (LPN #3) and the resident. When LPN #3 exited the room she indicated the resident besides having pain frequently gets very anxious and scared, frequently saw "floating things" in the room. She indicated the resident had been so scared by what she thought she had seen that her arms had knocked over a glass of water on her head and face. The clinical record for Resident #28 was reviewed on 11/17/11 at 8:30 A.M. Resident #28 was admitted to the facility on 08/19/08 with diagnosis, including but not limited to multiple sclerosis, abnormal posture, anxiety. The medication orders for Resident #28 included an order for the antispychotic medication, Seroquel 100 mg to be given at bedtime. The resident had diagnoses, including but not limited to major depression with psychotic features and delusions. It was unclear what Seroquel was to treat and whether the psychotic features included delusional behavior. Review of the behavior tracking forms and the electronic nursing progress notes, from 11/14/11 - 11/17/11, indicated there was no documentation of the resident's		plan review to ensure all behavioral issues and antipsychotic medications have been addressed on the plan of care. 3. DON to in-service nursing staff regarding attempted interventions before use of a PRN Ambien, appropriate diagnosis to be used for antipsychotics and the documentation of symptoms of insomnia. 4. DON/ADON/Social Services to review the 24 hour report sheets, physician's orders and resident progress notes daily to ensure appropriate interventions are attempted prior to administration of Ambien, any antipsychotic medication changes ensuring a documented need is in place. All findings to be discussed daily during Departmental Morning Meetings ongoing. Behavior Committee will continue to meet weekly to monitor for medication use, changes, gradual dose reductions, behavioral side effects, etc. ongoing. QA Committee to conduct ongoing quarterly meetings to ensure behavioral committee meetings occur and are addressing the monitoring previously listed. 5. To be completed by 12/16/11.	

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	delusional behaviors which had occurred on 11/16/11 from 8:40 A.M. - 9:00 A.M. when the resident had been scared due to seeing "floating things" in her room. The resident's anxiety and pain were documented as well as the resident's yelling out and need to be medication with additional anxiety medication, but there were no delusional behavior documented. 2. During the initial tour of the facility, conducted on 11/17/11 between 10:30 A.M. - 11:15 A.M., LPN #2 indicated Resident #26 was usually alert and oriented, had fallen recently and had rolled out of bed recently. The clinical record for Resident #26 was reviewed on 11/16/11 at 9:20 A.M. A physician's order, dated 04/13/11, indicated an order for Ambien, a medication to induce sleep, 5 mg by mouth at bedtime as needed for insomnia for 60 days. Another order, dated 06/24/11, indicated the same medication was ordered for another 30 days. On 07/19/11, an order for Ambien 5 mg po every night at bedtime was ordered for insomnia. Nursing progress notes, from 06/24/11 - 7/19/11 indicated only one note, dated			

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	07/16/11 at 20:00 (8:00 P.M.) which indicated the resident had been medicated with Ambien to help her sleep. There were no other alternatives documented as having been attempted prior to administering the Ambien to Resident #26. There was no other documentation of any insomnia behaviors documented and no indication as to why the sleeping medication ordered as needed had been increased to be given routinely. Review of the Medication Administration Record (MAR) for July 2011 indicated the resident had received the as needed Ambien medication 18 of the 19 nights prior to 07/20/11 when the medication order changed the medication administration to a routine basis. Again, there was no documentation to indicate other non-pharmacological interventions attempted prior to administering the Ambien medication and no documentation to assess if the medication was effective for treating the resident's insomnia. Interview with the Director of Nursing, on 11/17/11 at 2:30 P.M., indicated there was no further information or documentation regarding resident #26's insomnia. 3. Resident #2's record was reviewed			

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	11-15-11 at 2:25 p.m. Resident 32's diagnoses included but were not limited to dementia with behavioral disturbances, depression, and anemia. The original order for Risperdal, a psychotropic medication, was initiated on 10/03/11 at the dose of 0.25 mg qd for dementia with behavioral disturbances. A review of Resident #2's Minimum Data Set, dated 10-23-11, indicated Resident #2 had no behaviors in that assessment period. Nurse's progress noted, dated 10-23-11 to 11-8-11, did not indicated Resident #2 had become agitated or exhibited any behavior. A review of behavior tracking for October and November 2011 indicated Resident #2 had not had any behaviors until 11-8-11. A Behavior Data Collection Tool, dated 11-8-11 at 9:29 p.m., indicated Resident #2 had been banging on the door, hitting and pushing staff on the evening shift. A physician's order, dated 11-9-11, indicated to increase Resident #2's Risperdal (a medicine for psychosis) from 0.25 milligrams everyday to 0.5 milligrams everyday.			

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In an interview on 11-15-11 at 3:10 p.m., the Nurse Consultant indicated the Risperdal should have had more of an indication for use prior to increasing the medication.

4. Resident #71's closed record was reviewed 11-17-11 at 1:27 p.m. Resident #71's diagnoses included but were not limited to depression, anxiety, and anemia.

Resident # 71's Minimum Data Set, dated 8-2-11, indicated Resident #71 was feeling tired, had a poor appetite, and was experiencing little pleasure in life, but was not having difficulty sleeping.

Resident #71's Nurse's progress notes, dated 7-26-11 through 8-10-11, did not indicate Resident #71 was having difficulty sleeping.

A note on the psychiatry assessment, dated 8-9-11, indicated to initiate Trazadone (a medication to assist with sleep) 50 milligrams daily.

A review of Behavior Collection Data tools did not indicate Resident #71 was having difficulty sleeping.

In an interview on 11-17-11 at 2:45 p.m.,

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	the Social Services Director indicated she was unsure why Resident #71 had been placed on Trazadone. 5. Resident #57's clinical record was reviewed on 11/15/11 at 2:45 P.M. The record indicated the resident was admitted to the facility with diagnoses including, but not limited to, dementia. On 6/3/11, a physician's order was received to start the resident on Zyprexa (an antipsychotic medication) 5 milligrams (mg) once daily at bedtime for delusional behavior. A review of the resident's most recent health care plans indicated he did not have a health care plan to address delusional behavior. A Behavioral Assessment/Incident was documented on 5/17/11, where the resident had verbal aggression, increased confusion, was making false accusations and hearing voices. A Behavioral Assessment/Incident was documented on 6/5/11, where the resident refused to return to his home unit in the facility and stated someone was trying to kill him. An interview with the Social Service			

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	Director (SSD) on 11/16/11 at 10:35 A.M., indicated she believed the medical symptoms for the use of Zyprexa were anxiety, dementia and depression. The SSD indicated the resident should have had a health care plan to address Zyprexa use. An interview with the Director of Nursing (DN) on 11/16/11 at 11:00 A.M., indicated the resident had been put on Zyprexa for delusional behavior. An interview with the DN on 11/17/11 at 9:55 A.M., indicated she located no information about a health care plan for delusional behavior and there was no monitoring for delusional behavior. An interview with CNA #6 on 11/16/11 at 10: 45 A. M., indicated the resident's behaviors are he sometimes gets upset when staff have to help him with his activities of daily living. CNA #6 did not indicate the resident had delusional behaviors. An interview with LPN #7 on 11/16/11 at 11:25 A.M., indicated the resident receives Zyprexa for a diagnosis of behavioral disturbances and the resident gets upset when family come around. An interview with LPN #8 on 11/16/11 at			

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	2:50 P.M., indicated the resident gets Zyprexa due to sometimes he gets upset and tries to strike out when staff help him. 3.1-48(a)(3) 3.1-48(a)(4)			
F0371 SS=E	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure adequate dating of open food items and refrigerator cleanliness on the Alzheimer's unit. This had the potential to affect 28 of 28 residents residing on the Alzheimer's unit. Findings include: 1. During environmental tour on 11-15-11 at 9:42 a.m., the refrigerator on the Alzheimer's unit was observed to have numerous orange and red splatters on the inside of the refrigerator. Some splattered areas were about 2 inches long. The freezer was observed to have several yellowish and red splatters; some approximately 1 inch long.	F0371	This Plan of Correction is prepared and executed because the provision of State and Federal law require it and not because Englewood Health and Rehabilitation Center agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor are they of such character so as to limit our capability to render adequate care. 1. The facility has removed all foods that were outdated from the Alzheimer unit refrigerator. Refrigerator was cleaned. 2. The Alzheimer Unit's 26 residents potentially could be affected. The facility policy and procedure on cleaning refrigerators in common areas was reviewed and updated by the	12/16/2011

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	In an interview on 11-15-2011 at 9:45 a.m., the Maintenance Director indicated the refrigerator should be cleaned by the kitchen staff or Alzheimer's unit staff. A daily cleaning schedule provided by the Administrator on 11-16-2011 at 10:15 a.m., did not indicate when the refrigerator was to be cleaned. In an interview on 11-16-2011 at 10:15 a.m., the Administrator indicated there was no specific policy addressing the refrigerator on the Alzheimer's unit, but kitchen staff was to be responsible for cleaning the refrigerator. 2. During environmental tour on 11-15-11 at 9:42 a.m., in the refrigerator on the Alzheimer's unit, the following was observed: an open undated pint of 2% milk without an expiration date; three blue bowls with lids containing food stuffs were undated; 4 half gallon pitchers- 2 containing orange liquid, 1 full, one half full; 1 containing light peach colored liquid- 1/4 full, and 1 full pitcher containing red liquid were undated and unlabeled; one quart honey thick orange juice dated 8-30-11, a nectar thick lemon juice dated 9-20-11, a nectar thick apple juice dated 9-20-11, and a nectar thick orange juice dated 9-13-11. In the freezer section of the refrigerator the following		Administrator, Dietary Manager, Consultant Dietitian, and Housekeeping Supervisor. Specific tasks were assigned. 3. A dietary employee will monitor dates of food items in the refrigerator 5X/week. A monitoring tool will be completed. Housekeeping will ensure refrigerator cleanliness daily. Dietary and Nursing staff will be inserviced on 12/12/11 concerning the policy and procedure for labeling and dating all stored foods and for keeping the refrigerators in common areas clean. 4. Dietary will use a monitoring tool for checking expiration dates of stored foods in Alzheimer Unit's refrigerator. Housekeeping will monitor cleanliness. Dietary and Housekeeping will report progress to Quality Assurance Committee in their monthly meetings. 5. To be completed by 12/16/11.	

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	was observed: an open gallon of strawberry swirl ice cream 3/4 full and undated; half gallon of vanilla ice cream 3/4 full open and undated and a brown frozen substance in a Wendy's cup dated 10-8-11. In an interview on 11-16-11 at 10:15 a.m., the Administrator indicated food stuffs were to be dated after being opened. A policy regarding dating of food stuffs in the refrigerator was requested at exit on 11-15-11 and 11-16-11. A policy was not provided. 3.1-21(i)(1)(2)			

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F0431 SS=D	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure safe storage of emergency box medications. This had the potential to affect 4 residents in the facility. The facility further failed to ensure medications were disposed of adequately after discharge for 1 of 2 closed records	F0431	This Plan of Correction is prepared and executed because the provision of State and Federal law require it and not because Englewood Health and Rehabilitation Center agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not jeopardize the	12/16/2011

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	155654	A. BUILDING 00 B. WING	11/17/2011

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	reviewed for medication disposition in a sample of 16. (Resident #71) Findings include: 1. On entry to the facility at 10:15 a.m. on 11-14-11, the emergency drug kit was observed sitting open and unattended on the nurse's desk in reach of four residents sitting in the lobby at the time. The main box had three smaller sealed boxes in it. There was a smaller box labeled "G" open and unsecured. The box contained several oral antibiotics and three vials of unconstituted injectable antibiotics. On 11-14-11 at 10:22 a.m., LPN #1 came to the desk and secured the medications. During an interview on 11-14-11 at 10:25 a.m., LPN #1 indicated the medications were to be kept in a locked area, and under the supervision of a nurse. She further indicated the medications should not have been left open and unattended. On 11-14-11 at 10:25 a.m., LPN #1 indicated during an interview there were four residents sitting in the lobby, one was mobile and alert and oriented, two residents were mobile and confused and one resident was not mobile and was confused.		health and safety of residents, nor are they of such character so as to limit our capability to render adequate care. 1. The facility is unable to correct the previous alleged safe storage of medication as well as the disposition of resident # 71's medications alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practices. 3. DON to in-service the Nursing staff regarding the safe storage of emergency medication boxes and the adequate disposition of medications. DON/ADON to conduct random Licensed Nursing staff interviews weekly discussing the appropriate safe storage of medications as well as drug disposition weekly x's 4 weeks, twice monthly x's 2 months and then quarterly ongoing and upon hire of any new licensed employee orientation. 4. Medical Records to audit all discharged residents to ensure that appropriate disposition of medications have occurred and audits to be reviewed by the DON/Designee upon completion. Medical Records audits to be discussed at QA Committee Meetings quarterly ongoing. DON or designee will complete a QA tool weekly for 6 weeks and monthly thereafter to monitor for compliance. Results will be forwarded to the QA Committee. 5. To be completed by 12-16-11.	

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	A policy titled storage of Medications dated 2/2005 indicated compartments containing medications were to be locked when not in use. 2. Resident #71's closed record was reviewed 11-17-11 at 1:27 p.m. Resident #71's diagnoses included but were not limited to depression, anxiety, and anemia. Resident #71's medications at the time of his discharge on 10-17-11 included Norvasc 10 milligrams, Flexeril 10 milligrams, Cymbalta 90 milligrams, Periactin 4 milligrams, Senokot, Multivitamins, Trazadone 100 milligrams, Vitamin C, Oxycontin 40 milligrams, and Coumadin 6 milligrams. A review of Resident #71's record revealed no medication disposition on his record. A Nurse's progress note, dated 10-17-11 at 7:45 p.m., indicated Resident #71 was given instructions on his medications and prescriptions were given to be filled. In an interview on 11-17-11 at 3:22 p.m., the Administrator indicated there was no further information regarding Resident #71's medication disposition. The			

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	Administrator additionally indicated the disposition of the medications should have been documented. A current policy, dated 6/2005, titled Storage of Medications indicated all discontinued, outdated, or deteriorated medications will be destroyed or sent back to the pharmacy. 3.1-25(m) 3.1-25(r) 3.1-25(s)			
F9999	3.1-14 PERSONNEL 1. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read,	F9999	F9999 3.1-14 Personnel This Plan of Correction is prepared and executed because the provision of State and Federal law require it and not because Englewood Health and Rehabilitation Center agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor are they of such character so as to limit our capability to render adequate care. 1. The facility is unable to correct the alleged previous deficient practice for employees 11, 12, 13, 14, 15, 16, 17, 18 and	12/16/2011

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	and by whom administered. The tuberculin skin test must be read prior to the employee starting work. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure 9 of 10 employees reviewed had documentation of a physical examination completed prior to employment. (Employee #11, 12, 13, 14, 15, 16, 17, 18, and 19) In addition, 1 of 10 employees reviewed did not have a first step Mantoux tuberculin skin test completed prior to employment. (Employee #15) Findings include: Review of the personnel files, completed on 11/17/11 between 10:30 A.M. - 12:00 P.M., indicated the following physical examinations were signed, via a photocopied signature by a physician but were undated: Employee #11, hired 09/12/11 Employee #12, hired 09/12/11 Employee #13, hired 08/01/11 Employee #14, hired 08/16/10 Employee #15, hired 07/05/11 Employee #16, hired 08/15/11 Employee #17, hired 07/15/11 Employee #18, hired 08/15/11		19. There were no residents affected. 2. There were no residents affected on the alleged deficient practice. 3. HR Coordinator will review all employee files to ensure all areas of compliance are met prior to employment. Facility will establish a monitoring tool for employee files prior to employment. 4. HR Coordinator will complete a QA tool weekly for the next 6 weeks and monthly thereafter to monitor for compliance. Results will be forwarded to the QA committee. 5. To be completed by 12/16/11. F9999 3.1-9 Personal Property This Plan of Correction is prepared and executed because the provision of State and Federal law require it and not because Englewood Health and Rehabilitation Center agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor are they of such character so as to limit our capability to render adequate care. 1. The facility is unable to correct the alleged previous deficient practice for resident # 70	

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	There was no physical examination documentation for Employee #19, hired 11/02/11. Interview with the Administrator, on 11/17/11 at 1:55 P.M. indicated he could not locate any physical examination for Employee #19. He indicated she had been a rehire. Employee #15, hired on 07/05/11, had no Mantoux tuberculin skin testing documentation until 10/18/11. 3.1-14(t) 3.1-9 PERSONAL PROPERTY 1. (g) The facility must inventory, upon admission and discharge, the personal effects, money, and valuables declared by the resident at the time of admission. It is the resident's responsibility to maintain and update the inventory listing of the resident's personal property. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure personal inventories were complete and included on the medical record for 2 of 2 closed records reviewed for personal inventories in a sample of 16. (Resident #70,		and 71. 2. All other residents have the potential to be affected by the alleged deficient practice. 3. Medical Records will review all resident's personal inventory sheets to ensure they have been completed and signed. 4. Medical Records will complete a QA tool weekly for the next 6 weeks and monthly thereafter to monitor for compliance. Results will be forwarded to the QA committee. 5. To be completed by 12/16/11.	

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	Resident #71) Findings include: 1. Resident #70's closed record was reviewed 11-17-11 at 7:00 a.m. Resident #70's diagnoses included but were not limited to diabetes, anemia, and kidney failure. A review of Resident #70's Inventory of Personal Effects revealed the inventory had not been signed on admission or discharge. In an interview on 11-17-11 at 3:22 p.m., the Nurse Consultant indicated the personal inventory should have been completed and signed. 2. Resident #71's closed record was reviewed 11-17-11 at 1:27 p.m. Resident #71's diagnoses included but were not limited to depression, anxiety, and anemia. A review of Resident #71's record did not indicate an inventory of personal effects had been completed. In an interview on 11-17-11 at 3:22 p.m., the Administrator indicated no further information could be found relating to Resident #71's personal inventory.			

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	In an interview 11-17-11 at 3:22 p.m., the Nurse Consultant indicated there was no specific policy for completion of Personal Inventories. 3.1-9(g)			